



AGENCY OF HUMAN SERVICES
DEPARTMENT OF DISABILITIES, AGING AND INDEPENDENT LIVING

Division of Licensing and Protection
103 South Main Street, Ladd Hall
Waterbury, VT 05671-2306
<http://www.dail.vermont.gov>
Voice/TTY (802) 871-3317
To Report Adult Abuse: (800) 564-1612
Fax (802) 871-3318

June 12, 2012

Ms. Judy Morton, Administrator
Mountain View Center Genesis Healthcare
9 Haywood Avenue
Rutland, VT 05701

Provider #: 475012

Dear Ms. Morton:

Enclosed is a copy of your acceptable plans of correction for the survey and complaint investigation conducted on **May 14, 2012**. Please post this document in a prominent place in your facility.

We may follow up to verify that substantial compliance has been achieved and maintained. If we find that your facility has failed to achieve or maintain substantial compliance, remedies may be imposed.

Sincerely,

A handwritten signature in cursive script, appearing to read "Pamela M. Cota".

Pamela M. Cota, RN, MS
Licensing Chief

PC:ne

Enclosure

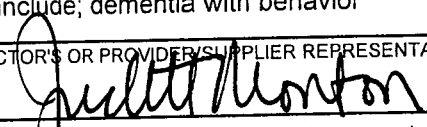


DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 475012	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 05/14/2012
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NAME OF PROVIDER OR SUPPLIER MOUNTAIN VIEW CENTER GENESIS HEALTHCARE	STREET ADDRESS, CITY, STATE, ZIP CODE 9 HAYWOOD AVENUE RUTLAND, VT 05701
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS	F 000	The Center's filing of this plan of correction does not constitute an admission to any of the alleged citations set forth in this statement of deficiency. The Center files this plan of correction as evidence of the Center's continued compliance with all applicable federal and state laws and regulations.	
F 223 SS=D	<p>483.13(b), 483.13(c)(1)(i) FREE FROM ABUSE/INVOLUNTARY SECLUSION</p> <p>The resident has the right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion.</p> <p>The facility must not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion.</p> <p>This REQUIREMENT is not met as evidenced by: Based on staff interview and record review the facility failed to ensure that one resident identified (Resident #1), was free of humiliation and mental abuse. The findings include:</p> <p>Per review of the facility's internal investigation on 5/14/12, the investigation indicated that on 3/21/12 the facility was notified by the corporate compliance hotline that an incident occurred on 3/19/12 involving Resident #1, who was in the dining room on Cherry Tree Lane at 8:00 AM and placed an adult brief (incontinence product) that was soiled with feces on his/her head and that an Licensed Nursing Assistant(LNA) took a picture of the incident.</p> <p>Per record review on 5/14/12, Resident #1 was admitted to the facility on 12/23/10 with diagnoses that include; dementia with behavior</p>	F 223	<p>F223 Resident #1 is stable and the center has not seen any changes in mood or behavior from incident.</p> <p>All center staff will receive education regarding abuse and reporting.</p> <p>Administrator/Designee to audit random staff interaction with residents to ensure that resident's physical, emotional health and welfare are maintained monthly x 3 months. The results of these audits will be reported by the Administrator to the CQI Committee. The CQI Committee will evaluate for further recommendations.</p> <p>Oversight: Administrator</p> <p>F223 POC accepted 6/12/12 McLennan RN, Amatore RN</p>	6-14-12

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE Administrator	(X6) DATE 5-31-12
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Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that the institution's safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

pmc

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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OMB NO. 0938-0391

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F 223	<p>Continued From page 1</p> <p>disturbances, anxiety, and senile depressive disorder. Per review of the MDS (Comprehensive Assessment) dated 2/7/12, Resident #1 had both long and short term memory issues, impaired decision making, continuous inattentive behavior, and physical behaviors occurring daily , other behaviors not directed at others, rejecting care and wandering..</p> <p>Per interview with a staff RN (RN#1) on 5/14/12 at 9:22 AM, he/she stated that he/she " saw an LNA (LNA#1) laughing and taking a picture with his/her cell phone of Resident #1 wearing an adult brief on his/her head and an RN#2 posing for the picture. RN#1 stated that the brief contained feces. Per RN #1, he/she stated that it " did not register until after the picture was taken that this was wrong. " RN#1 stated that staff should " not be laughing and taking pictures that this was an indignity to Resident #1 and he/she knew that laughing at the resident and taking the picture was abusive to Resident #1.</p> <p>Per interview with a staff RN (RN#2) on 5/14/12 at 9:41 AM, he/she stated that on 3/19/12 he/she was present when Resident #1 was in the dining room with a feces soiled adult brief on his/her head. The RN#2 indicated that he/she was passing medications and saw Resident #1 wandering and picking up things. RN#2 saw the resident near the television and went over to redirect the resident away, since in the past Resident #1 had been known to pull things down onto him/herself. RN#2 stated he/she did not realize that a picture was being taken. RN#2 stated that " Resident #1 does things like wear things on his/her head like towels and we laugh at him/her at times " . RN#2 stated " that it was</p>	F 223		

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F 223	<p>Continued From page 2</p> <p>abusive to the resident and that RN#2 in hindsight could have stopped it but he/she was concerned with getting things done. " RN#2 stated that he/she was reprimanded for dignity, failure to stop an incident and failure to report an incident.</p> <p>Per interview with the UM (Unit Manager) on 5/14/12 at 9:50 AM, he/she indicated that he/she was in the building at the time the incident occurred but no one informed him/her until midway through 3/20/12 when the UM received a call from RN#1. The UM stated that RN#1 told the UM that LNA#1 had taken a picture of Resident #1 in the dining room on 3/19/12 wearing a adult brief soiled with feces on his/her head. The UM stated that he/she spoke to the RN#2 who posed in the picture and spoke to the LNA#1 who took the picture and was laughing and thought the incident was funny, The UM stated it was a " lapse in judgment ". The UM stated that if no picture was taken after Resident #1 placed the brief on her head then it would not be considered abuse, that it became abuse when the picture was taken and could be considered exploitation". The UM indicated that he /she was aware of 2 RN ' s and 2 LNA ' s involved in the incident. The UM stated that he/she has faith in his/her staff that they are doing the right thing. "</p> <p>Per interview with the facility Administrator on 5/14/12 at 10:35 AM, he/she stated that he/she received a call from the corporate office on 3/21/12, that someone had called the corporate compliance hotline regarding the incident on Cherry Tree Lane. The Administrator stated that all of those involved " admitted participation ". The Administrator stated his/her " expectation of staff was that they not take pictures of residents</p>	F 223		

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F 223	Continued From page 3 without their permission and that LNA#1 should not have been joking and not taking pictures. " The Administrator stated that " due to the cognition of Resident #1, that Resident #1 had no idea the incident occurred and there was no harm to resident and that it was not abuse. " Per interview with the DNS on 5/14/12 at 10:35 AM, he/she stated that his/her concern was that this was a respect and dignity issue, and his/her specific concern was that a picture was taken and the staff did not stop the incident from occurring and laughing at it. " Per interview on 5/14/12 at 10:35 AM, the DNS stated that this was not abuse, that Resident #1 was not interviewable and had no recollection of the incident occurring when asked in passing. " Per interview with the Administrator on 5/14/12 at 11:43 AM, he/she indicated that the education done on abuse prohibition on 3/30/12 was done to educate the staff on reporting and not because " abuse had occurred. " Per review of the facility's policy and procedure on 5/14/12 titled; Abuse Prohibition, the policy indicates that "Abuse is defined as any action (including unnecessary restraint or confinement) that threatens a vulnerable adult's physical or emotional health or welfare."	F 223			
F 225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide	F 225			

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MOUNTAIN VIEW CENTER GENESIS HEALTHCARE

STREET ADDRESS, CITY, STATE, ZIP CODE

9 HAYWOOD AVENUE
RUTLAND, VT 05701

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F 225	<p>Continued From page 4</p> <p>registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities.</p> <p>The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).</p> <p>The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.</p> <p>The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.</p> <p>This REQUIREMENT is not met as evidenced by: Based on staff interview and record review the facility failed to ensure that all alleged violations involving mistreatment, neglect or abuse are reported immediately to the Administrator of the</p>	F 225	<p>F225</p> <p>Resident #1 is stable and the center has not seen any changes in mood or behavior from incident.</p> <p>Involved staff received disciplinary action on 3/22/12</p> <p>center staff will receive education regarding abuse and reporting</p> <p>Center to audit cases of suspected abuse for timely reporting monthly x 3.</p> <p>The results of these audits will be reported by the Administrator to the CQI Committee. The CQI Committee will evaluate for further recommendations.</p> <p>F225 POC accepted 6/12/12 McLennan RN / Pincot RN</p>	6-14-12

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F 225	<p>Continued From page 5</p> <p>facility and to other officials in accordance with State law through established processes for one resident identified (Resident #1). The findings include:</p> <p>Per review of the facility's internal investigation on 5/14/12, the investigation indicated that on 3/21/12 the facility was notified by the corporate compliance hotline that an incident occurred on 3/19/12 involving Resident #1, who was in the dining room on Cherry Tree Lane at 8:00 AM and placed a adult brief (incontinence product) that was soiled with feces on his/her head and an Licensed Nursing Assistant(LNA)t took a picture of the incident</p> <p>Per record review on 5/14/12, Resident #1 was admitted to the facility on 12/23/10 with diagnoses that include; dementia with behavior disturbances, anxiety, and senile depressive disorder. Per review of the MDS (Comprehensive Assessment) dated 2/7/12, Resident #1 had both long and short term memory issues, impaired decision making, continuous inattentive behavior, physical behaviors occurring daily , other behaviors not directed at others, rejecting care and wandering.</p> <p>Per interview with a staff RN (RN#1) on 5/14/12 at 9:22 AM, he/she stated that he/she " saw an LNA (LNA#1) laughing and taking a picture with his/her cell phone of Resident #1 wearing an adult brief on his/her head and an RN#2 posing for the picture. RN#1 stated that the brief contained feces. Per RN #1, he/she stated that it " did not register until after the picture was taken that this was wrong. " RN#1 stated that staff should " not be laughing and taking pictures that</p>	F 225		

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F 225	<p>Continued From page 6</p> <p>this was an indignity to Resident #1 and he/she knew that laughing at the resident and taking the picture was abusive to Resident #1. RN#1 stated that he/she called the Unit Manager (UM) the next day(3/20/12) and asked the UM not to report the incident because RN#1 " did not want to get anyone into trouble, that it was a mistake that caused abuse, but was sure staff would never do it again. " Per RN#1, he/she indicated that he/she did not call Administration, the corporate compliance hotline or any state agency to report the incident.</p> <p>Per interview with a staff RN (RN#2) on 5/14/12 at 9:41 AM, he/she stated that on 3/19/12 he/she was present when Resident #1 was in the dining room with a feces soiled adult brief on his/her head. The RN#2 indicated that he/she was passing medications and saw Resident #1 wandering and picking up things. RN#2 saw the resident near the television and went over to redirect the resident away, since in the past Resident #1 had been known to pull things down onto him/herself. RN#2 stated he/she did not realize that a picture was being taken. RN#2 stated that " Resident #1 does things like wear things on his/her head like towels and we laugh at him/her at times ". RN#2 stated " that it was abusive to the resident and that RN#2 in hindsight could have stopped it but he/she was concerned with getting things done. " RN#2 stated that he/she was reprimanded after 3/21/12 for dignity, failure to stop an incident and failure to report an incident.</p> <p>Per interview with the UM on 5/14/12 at 9:50 AM, he/she indicated that he/she was in the building at the time the incident occurred on 3/19/12 but no</p>	F 225		

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F 225	<p>Continued From page 7</p> <p>one informed him/her until midway through 3/20/12 when the UM received a call from RN#1. The UM stated that RN#1 told the UM that LNA#1 had taken a picture of Resident #1 in the dining room on 3/19/12 wearing a adult brief soiled with feces on his/her head. The UM stated that he/she spoke to the RN#2 who posed in the picture and spoke to the LNA#1 who took the picture and was laughing and thought the incident was funny, The UM stated it was a " lapse in judgment ". The UM stated that if no picture was taken after Resident #1 placed the brief on his/her head then it would not be considered abuse, that it became abuse when the picture was taken and could be considered exploitation. The UM indicated that he /she was aware of 2 RN ' s and 2 LNA ' s involved in the incident. The UM stated that he/she has faith in his/her staff that they are doing the right thing. " The UM stated that he/she had been reprimanded after 3/21/12 for not reporting the incident."</p> <p>Per interview with the facility Administrator on 5/14/12 at 10:35 AM, he/she stated that he/she received a call from the corporate office on 3/21/12, that someone had called the corporate compliance hotline regarding the incident on Cherry Tree Lane. The Administrator stated that all of those involved " admitted participation ". The Administrator stated his/her " expectation of staff was that they not take pictures of residents without their permission and that LNA#1 should not have been joking and not taking pictures. "</p> <p>Per interview with the DNS on 5/14/12 at 10:35 AM, he/she stated that his/her concern was that this was a respect and dignity issue, and his/her specific concern was that a picture was taken and</p>	F 225		

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F 225	<p>Continued From page 8</p> <p>the staff did not stop the incident from occurring and laughing at it. " The DNS stated his/her expectation is that staff protect the resident then report to a supervisor, Administration or the hotline or any one they are comfortable reporting to. "</p> <p>Per interview on 5/14/12 at 10:35 AM, the Administrator stated that the LNA#1 was terminated for " taking a picture of a resident without permission. The Administrator stated that RN#2 was reprimanded with a written warning for " not supervising the LNA and stopping the incident from occurring". The Administrator stated the UM was reprimanded for not informing the Administrator or Director of Nursing (DNS) about the incident.</p> <p>Per interview with the Administrator on 5/14/12 at 11:43 AM, he/she indicated that the education done on abuse prohibition on 3/30/12 was done to educate the staff on reporting and not because " abuse had occurred. "</p> <p>Per review of the employee files on 5/14/12 indicated the UM was reprimanded for " failing to comply with policies regarding resident rights, HIPAA, abuse and neglect reporting surrounding a recent event on Cherry Tree Lane where an LNA took a picture of a resident on his/her cell, and when the situation was made aware to the UM, he/she did not make Administration or the DNS aware so that proper action could be taken this resulted in a delay in reporting to appropriate agencies.</p> <p>Per review of the facility reportable events document on 5/14/12, the document states;</p>	F 225			

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F 225	Continued From page 9 "Reporting incidences of abuse and neglect is your professional and moral duty."	F 225		
F 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review the facility failed to ensure for one resident (Resident #1), that care was provided in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his/her individuality. The findings include: Per review of the facility's internal investigation on 5/14/12, the investigation indicated that on 3/21/12 the facility was notified by the corporate compliance hotline that an incident occurred on 3/19/12 involving Resident #1, who was in the dining room on Cherry Tree Lane at 8:00 AM and placed a adult brief (incontinence product) that was soiled with feces on his/her head and an Licensed Nursing Assistant(LNA)t took a picture of the incident Per record review on 5/14/12, Resident #1 was admitted to the facility on 12/23/10 with diagnosis that include; dementia with behavior disturbances, anxiety, and senile depressive disorder. Per review of the MDS (Comprehensive Assessment) dated 2/7/12, Resident #1 had both long and short term memory issues, impaired	F 241	F241 Resident #1 is currently stable and the center has not seen any changes in mood or behavior from incident. Center staff will receive education regarding abuse, reporting and resident dignity. Center to audit cases of suspected abuse for timely reporting monthly x 3. The results of these audits will be reported by the Administrator to the CQI Committee. The CQI Committee will evaluate for further recommendations F241 POC accepted 6/12/12 McLuhman RN/ Pmooturn	6-14-12

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NAME OF PROVIDER OR SUPPLIER MOUNTAIN VIEW CENTER GENESIS HEALTHCARE	STREET ADDRESS, CITY, STATE, ZIP CODE 9 HAYWOOD AVENUE RUTLAND, VT 05701
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F 241	<p>Continued From page 10</p> <p>decision making, continuous inattentive behavior, physical behaviors occurring daily , other behaviors not directed at others, rejecting care and wandering.</p> <p>Per interview with a staff RN (RN#1) on 5/14/12 at 9:22 AM, he/she stated that he/she " saw an LNA (LNA#1) laughing and taking a picture with his/her cell phone of Resident #1 wearing an adult brief on his/her head and an RN#2 posing for the picture. RN#1 stated that the brief contained feces. Per RN #1, he/she stated that it " did not register until after the picture was taken that this was wrong. " RN#1 stated that staff should " not be laughing and taking pictures that this was an indignity to Resident #1 and he/she knew that laughing at the resident and taking the picture was abusive to Resident #1.</p> <p>Per interview with a staff RN (RN#2) on 5/14/12 at 9:41 AM, he/she stated that on 3/19/12 he/she was present when Resident #1 was in the dining room with a feces soiled adult brief on his/her head. The RN#2 indicated that he/she was passing medications and saw Resident #1 wandering and picking up things. RN#2 saw the resident near the television and went over to redirect the resident away, since in the past Resident #1 had been known to pull things down onto him/herself. RN#2 stated he/she did not realize that a picture was being taken. RN#2 stated that " Resident #1 does things like wear things on his/her head like towels and we laugh at him/her at times " . RN#2 stated " that it was abusive to the resident and that RN#2 in hindsight could have stopped it but he/she was concerned with getting things done. "</p> <p>Per interview with the UM (Unit Manager) on</p>	F 241		

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NAME OF PROVIDER OR SUPPLIER

MOUNTAIN VIEW CENTER GENESIS HEALTHCARE

STREET ADDRESS, CITY, STATE, ZIP CODE

**9 HAYWOOD AVENUE
RUTLAND, VT 05701**

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F 241	<p>Continued From page 11</p> <p>5/14/12 at 9:50 AM, he/she stated that RN#1 told the UM that LNA#1 had taken a picture of Resident #1 in the dining room on 3/19/12 wearing a adult brief soiled with feces on his/her head. The UM stated that he/she spoke to the RN#2 who posed in the picture and spoke to the LNA#1 who took the picture and was laughing and thought the incident was funny, The UM stated it was a " lapse in judgment ". The UM stated that if no picture was taken after Resident #1 placed the brief on her head then it would not be considered abuse, that it became abuse when the picture was taken and could be considered exploitation. The UM indicated that he /she was aware of 2 RN ' s and 2 LNA ' s involved in the incident. The UM stated that he/she has faith in his/her staff that they are doing the right thing. "</p> <p>Per interview with the facility Administrator on 5/14/12 at 10:35 AM, he/she stated that he/she received a call from the corporate office on 3/21/12, that someone had called the corporate compliance hotline regarding the incident on Cherry Tree Lane. The Administrator stated that all of those involved " admitted participation ". The Administrator stated his/her " expectation of staff was that they not take pictures of residents without their permission and that LNA#1 should not have been joking and not taking pictures. "</p> <p>The Administrator stated that " due to the cognition of Resident #1, that Resident #1 had no idea the incident occurred, there was no harm to resident that it was not abuse. "</p> <p>Per interview with the DNS on 5/14/12 at 10:35 AM, he/she stated that his/her concern was that this was a respect and dignity issue, and his/her specific concern was that a picture was taken and</p>	F 241		

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F 241	Continued From page 12 the staff did not stop the incident from occurring and laughing at it. " The DNS stated his/her expectation is that staff protect the resident then report to a supervisor, Administration or the hotline or any one they are comfortable reporting to. " Per interview on 5/14/12 at 10:35 AM, the DNS stated that this was not abuse, that Resident #1 was not interview able and had no recollection of the incident occurring when asked in passing. " Per interview on 5/14/12 at 10:35 AM, the Administrator stated that the LNA#1 was terminated for " taking a picture of a resident without permission. The Administrator stated that RN#2 was reprimanded with a written warning for " not supervising the LNA and stopping the incident from occurring. The Administrator stated the UM was reprimanded for not informing the Administrator or Director of Nursing (DNS) about the incident. Per review of the employee files on 5/14/12 indicated the UM was reprimanded for " failing to comply with policies regarding resident rights, HIPAA, abuse and neglect reporting surrounding a recent even on Cherry Tree lane where an LNA took a picture of a resident on his/her cell, and when the situation was made aware to the UM, he/she did not make Administration or the DNS aware so that proper action could be taken this resulted in a delay in reporting to appropriate agencies. "	F 241		
F 250 SS=D	483.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial	F 250		

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F 250	<p>Continued From page 13 well-being of each resident.</p> <p>This REQUIREMENT is not met as evidenced by: Based on staff interview and record review the facility failed to provide medically-related social services to attain or maintain the highest practicable physical, mental and psychosocial well-being for one resident identified (Resident #1). The findings include:</p> <p>Per review of the facility's internal investigation on 5/14/12, the investigation indicated that on 3/21/12 the facility was notified by the corporate compliance hotline that an incident occurred on 3/19/12 involving Resident #1, who was in the dining room on Cherry Tree Lane at 8:00 AM and placed a adult brief (incontinence product) that was soiled with feces on his/her head and an Licensed Nursing Assistant(LNA)t took a picture of the incident</p> <p>Per record review on 5/14/12, Resident #1 was admitted to the facility on 12/23/10 with diagnoses that include; dementia with behavior disturbances, anxiety, and senile depressive disorder. Per review of the MDS (Comprehensive Assessment) dated 2/7/12, Resident #1 had both long and short term memory issues, impaired decision making, continuous inattentive behavior, physical behaviors occurring daily , other behaviors not directed at others, rejecting care and wandering. Per record review on 5/14/12, there was no evidence that Social Services met with Resident #1 and assessed the potential effects of the incident of staff laughing and taking</p>	F 250	<p>F250 Resident #1 is stable and the center has not seen any changes in mood or behavior from incident</p> <p>Social workers to review cases of reported abuse to determine if other residents were affected.</p> <p>Social workers will be educated on updating care plans for residents with psychosocial needs.</p> <p>Care plans for patients who have reported cases of abuse will be audited monthly x 3. The results of these audits will be reported by the Administrator to the CQI Committee. The CQI Committee will evaluate for further recommendations</p> <p>Oversight: Administrator</p> <p>F250 POC accepted 6/12/12 McLuhnen RN / Amcota RN</p>	<p>6-14-12</p> <p>6-14-12</p>

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F 250	Continued From page 14 pictures of Resident #1 when the resident placed a feces soiled adult brief on his/her head in the dining room at 8:00 AM on 3/19/12. Per record review there was no evidence that Social Services assessed Resident #1 after the incident on 3/19/12 to assess for potential needs of Resident #1. Per review of Resident #1's medical record on 5/14/12 there was no evidence that the incident on 3/19/12 had occurred and there was no evidence that a plan was discussed or created to prevent Resident #1 from being the victim of future abuse. Per review on 5/14/12 of the comprehensive care plan last revised on 4/26/12 there was no evidence that the care plan was revised to reflect the resident's current status of being a victim of abuse and no reflection of any goals or interventions to prevent reoccurrence of abusive actions by others towards Resident #1. Per interview with the Social Service Worker on 5/14/12 at 12:17 PM, he/she stated that he/she "was made aware of the picture being taken by staff through hearsay and the incident was discussed at morning meeting that pictures should not be taken of residents." The Social Service Worker stated that he/she "did not meet with the resident" after the event occurred.	F 250			
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.	F 280			

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F 280	<p>Continued From page 15</p> <p>A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.</p> <p>This REQUIREMENT is not met as evidenced by: Based on staff interview and record review the facility failed to revise the comprehensive care plan for one resident identified (Resident #1) to reflect the actual mental abuse of the resident and the interventions and goals to prevent future potential incidences of abuse. The findings include:</p> <p>Per review of the facility's internal investigation on 5/14/12, the investigation indicated that on 3/21/12 the facility was notified by the corporate compliance hotline that an incident occurred on 3/19/12 involving Resident #1, who was in the dining room on Cherry Tree Lane at 8:00 AM and placed a adult brief (incontinence product) that was soiled with feces on his/her head and an Licensed Nursing Assistant(LNA)t took a picture of the incident</p> <p>Per record review on 5/14/12, Resident #1 was</p>	F 280	<p>F280</p> <p>Resident #1 is currently stable and the center has not seen any changes in mood or behavior from incident.</p> <p>Social workers to review cases of reported abuse to determine if other residents were affected.</p> <p>Social workers to be educated regarding updating care plans for residents with psychosocial needs.</p> <p>Care plans for patients who have reported cases of abuse will be audited and reviewed monthly x 3.</p> <p>The results of these audits will be reported by the Administrator to the CQI Committee. The CQI Committee will evaluate for further recommendations Oversight: Administrator</p> <p>F280 POC accepted 6/12/12 McLellan RN / Amcota RN</p>	<p>6-14-12</p> <p>6-14-12</p>

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F 280	<p>Continued From page 16</p> <p>admitted to the facility on 12/23/10 with diagnoses that include; dementia with behavior disturbances, anxiety, and senile depressive disorder. Per review of the MDS (Comprehensive Assessment) dated 2/7/12, Resident #1 had both long and short term memory issues, impaired decision making, continuous inattentive behavior, physical behaviors occurring daily , other behaviors not directed at others, rejecting care and wandering.</p> <p>Per interview with a staff RN (RN#1) on 5/14/12 at 9:22AM, he/she stated that he/she " saw an LNA (LNA#1) laughing and taking a picture with his/her cell phone of Resident #1 wearing an adult brief on his/her head and an RN#2 posing for the picture. RN#1 stated that the brief contained feces. Per RN #1, he/she stated that it " did not register until after the picture was taken that this was wrong. " RN#1 stated that staff should " not be laughing and taking pictures that this was an indignity to Resident #1 and he/she knew that laughing at the resident and taking the picture was abusive to Resident #1.</p> <p>Per interview with a staff RN (RN#2) on 5/14/12 at 9:41 AM, he/she stated that on 3/19/12 he/she was present when Resident #1 was in the dining room with a feces soiled adult brief on his/her head. The RN#2 indicated that he/she was passing medications and saw Resident #1 wandering and picking up things. RN#2 saw the resident near the television and went over to redirect the resident away, since in the past Resident #1 had been known to pull things down onto him/herself. RN#2 stated he/she did not realize that a picture was being taken. RN#2 stated that " Resident #1 does things like wear</p>	F 280		

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F 280	<p>Continued From page 17</p> <p>things on his/her head like towels and we laugh at him/her at times ". RN#2 stated " that it was abusive to the resident and that RN#2 in hindsight could have stopped it but he/she was concerned with getting things done. "</p> <p>Per interview with the UM (Unit Manager) on 5/14/12 at 9:50 AM, he/she stated that RN#1 told the UM that LNA#1 had taken a picture of Resident #1 in the dining room on 3/19/12 wearing an adult brief soiled with feces on his/her head. The UM stated that he/she spoke to the RN#2 who posed in the picture and spoke to the LNA#1 who took the picture and was laughing and thought the incident was funny, The UM stated it was a " lapse in judgment ". The UM stated that if no picture was taken after Resident #1 placed the brief on her head then it would not be considered abuse, that it became abuse when the picture was taken and could be considered exploitation. The UM indicated that he /she was aware of 2 RN ' s and 2 LNA ' s involved in the incident. The UM stated that he/she has faith in his/her staff that they are doing the right thing. "</p> <p>Per interview with the facility Administrator on 5/14/12 at 10:35 AM, he/she stated that he/she received a call from the corporate office on 3/21/12, that someone had called the corporate compliance hotline regarding the incident on Cherry Tree Lane. The Administrator stated that all of those involved " admitted participation ". The Administrator stated his/her " expectation of staff was that they not take pictures of residents without there permission and that LNA#1 should not have been joking and not taking pictures. " The Administrator stated that " due to the cognition of Resident #1, that Resident #1 had no</p>	F 280		

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F 280	<p>Continued From page 18</p> <p>idea the incident occurred and there was no harm to resident that it was not abuse. "</p> <p>Per interview with the DNS on 5/14/12 at 10:35 AM, he/she stated that his/her concern was that this was a respect and dignity issue, and his/her specific concern was that a picture was taken and the staff did not stop the incident from occurring and laughing at it. " The DNS stated his/her expectation is that staff protect the resident then report to a supervisor, Per interview on 5/14/12 at 10:35 AM, the DNS stated that this was not abuse, that Resident #1 was not interview able and had no recollection of the incident occurring when asked in passing. "</p> <p>Per review of Resident #1's medical record on 5/14/12 there was no evidence that the incident on 3/19/12 had occurred and there was no evidence that a plan was discussed or created to prevent Resident #1 from being the victim of future abuse. Per review on 5/14/12 of the comprehensive care plan last revised on 4/26/12 there was no evidence that the care plan was revised to reflect the resident's current status of being a victim of abuse and no reflection of any goals or interventions to prevent reoccurrence of abusive actions by others towards Resident #1.</p>	F 280		